

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041285</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Meadowbrook Manor-Naperville</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>720 Raymond Drive</u> <u>Naperville</u> <u>60563</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>DuPage</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(630) 355-0220</u> Fax # <u>(630) 305-6711</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
IDPA ID Number: <u>363782227001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u>	
Date of Initial License for Current Owners: <u>02/09/96</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Michael G. Kaplan</u> Telephone Number: <u>(312) 634-3400</u> <u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u>			

Please send copies of any desk review or audit adjustments to the above address.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor-Naperville# 0041285 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>235</u>	Skilled (SNF)	<u>235</u>	<u>86,010</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>235</u>	TOTALS	<u>235</u>	<u>86,010</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>49,226</u>	<u>13,337</u>	<u>5,336</u>	<u>67,899</u>	8
9	SNF/PED					9
10	ICF	<u>6,880</u>	<u>1,663</u>		<u>8,543</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>56,106</u>	<u>15,000</u>	<u>5,336</u>	<u>76,442</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.88%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 02/09/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 02/09/96NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 36 and days of care provided 5,336Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Meadowbrook Manor-Naperville

0041285

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	350,104	48,641	10,118	408,863		408,863		408,863			1
2	Food Purchase		358,103		358,103		358,103	(2,329)	355,774			2
3	Housekeeping	209,968	40,467		250,435		250,435		250,435			3
4	Laundry	73,921	22,455		96,376		96,376		96,376			4
5	Heat and Other Utilities			192,171	192,171		192,171		192,171			5
6	Maintenance	77,413	19,875	106,918	204,206		204,206		204,206			6
7	Other (specify):*											7
8	TOTAL General Services	711,406	489,541	309,207	1,510,154		1,510,154	(2,329)	1,507,825			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,084,884	227,163	34,381	3,346,428		3,346,428	420	3,346,848			10
10a	Therapy	115,636	3,306	28,199	147,141		147,141		147,141			10a
11	Activities	107,607	13,751	2,608	123,966		123,966		123,966			11
12	Social Services	67,006		2,660	69,666		69,666		69,666			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,375,133	244,220	91,848	3,711,201		3,711,201	420	3,711,621			16
	C. General Administration											
17	Administrative	137,100		81,375	218,475		218,475	(81,375)	137,100			17
18	Directors Fees											18
19	Professional Services			69,194	69,194		69,194	19,967	89,161			19
20	Dues, Fees, Subscriptions & Promotions			41,631	41,631		41,631	(630)	41,001			20
21	Clerical & General Office Expenses	300,285	31,747	76,783	408,815		408,815	7,304	416,119			21
22	Employee Benefits & Payroll Taxes			594,745	594,745		594,745	32,071	626,816			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,603	2,603		2,603	132	2,735			24
25	Other Admin. Staff Transportation			958	958		958		958			25
26	Insurance-Prop.Liab.Malpractice			87,818	87,818		87,818		87,818			26
27	Other (specify):*											27
28	TOTAL General Administration	437,385	31,747	955,107	1,424,239		1,424,239	(22,531)	1,401,708			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,523,924	765,508	1,356,162	6,645,594		6,645,594	(24,440)	6,621,154			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Meadowbrook Manor-Naperville

#0041285

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,073	36,073		36,073	343,574	379,647			30
31	Amortization of Pre-Op. & Org.			9,862	9,862		9,862	38,620	48,482			31
32	Interest			90,564	90,564		90,564	1,017,995	1,108,559			32
33	Real Estate Taxes							190,644	190,644			33
34	Rent-Facility & Grounds			2,400,000	2,400,000		2,400,000	(2,393,442)	6,558			34
35	Rent-Equipment & Vehicles			6,930	6,930		6,930		6,930			35
36	Other (specify):*											36
37	TOTAL Ownership			2,543,429	2,543,429		2,543,429	(802,609)	1,740,820			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		196,479		196,479		196,479		196,479			39
40	Barber and Beauty Shops			30,266	30,266		30,266		30,266			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,016	129,016		129,016		129,016			42
43	Other (specify):* Nonallowable costs			153,497	153,497		153,497	(153,497)				43
44	TOTAL Special Cost Centers		196,479	312,779	509,258		509,258	(153,497)	355,761			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,523,924	961,987	4,212,370	9,698,281		9,698,281	(980,546)	8,717,735			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Meadowbrook Manor-Naperville

0041285

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(2,329)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(101)	30		9
10 Interest and Other Investment Income	(10,389)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(750)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(4,600)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(90,512)	43		24
25 Fund Raising, Advertising and Promotional	(22,628)	43		25
26 Income Taxes and Illinois Personal				
Property Replacement Tax	(12,871)	43		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5A	(58,380)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (202,560)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense	38,620	31	33
34 Adjustments for Related Organization Costs (Schedule VII)	(816,606)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (777,986)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (980,546)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

BUTTERFIELD HEALTH CARE II, INC.
D/B/A MEADOWBROOK MANOR - NAPERVILLE
PROVIDER # 0041285
12/31/2000

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Disallow Patient Clothing	(603)	43
Disallow Travel and Entertainment	(25,686)	43
Disallow Casual Labor	(373)	43
Disallow Non-Patient Radiology	(4,722)	43
Disallow Non-Patient Physican's Fees	(3,423)	43
Disallow Non-Patient Laboratory	(200)	43
Disallow Non-allowable Licenses and Fees	(3,564)	20
Disallow Non-allowable Legal	(19,809)	19
Total Line 29 - Other	<u>(58,380)</u>	

See Accountants' Compilation Report

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
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77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

Facility Name & ID Number Meadowbrook Manor-Naperville

0041285

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dr. Kianoosh Jafari	25.00%	Butterfield Health Care, Inc.		Seneca Building		
Robert Jafari	25.00%	d/b/a Meadowbrook Manor - Bolingbrook	Bolingbrook	Partnership	DesPlaines	Lessor
Louis William Dimas Family Ltd. Ptshp.	20.00%			J&D Partners, L.P.	Bolingbrook	Lessor
Nicholas Vangel	20.00%	Seneca Nursing Home, Inc. d/b/a Lee Manor	DesPlaines	MMN Partners, L.P.	Naperville	Lessor
Eva Dimas	10.00%			Butterfield Health Care		
				Mgmt Group Inc.	Bolingbrook	Management Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V			2,400,000	MMN Partners, L.P (Page 6A)	100.00%	1,615,706	(784,294)	5
6	V								6
7	V			81,375	Butterfield Health Care Management Group (Page 6B)	100.00%	49,063	(32,312)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,481,375			\$ 1,664,769	\$ * (816,606)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor-Naperville

0041285

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Services	\$	MMN Partners, L.P.	100.00%	\$ 39,402	\$ 39,402	15
16	V	20 Fees and Subscriptions		MMN Partners, L.P.	100.00%	925	925	16
17	V	30 Depreciation		MMN Partners, L.P.	100.00%	343,480	343,480	17
18	V	32 Interest Expense		MMN Partners, L.P.	100.00%	1,028,384	1,028,384	18
19	V	33 Real Estate Taxes		MMN Partners, L.P.	100.00%	190,644	190,644	19
20	V	34 Rent	2,400,000	MMN Partners, L.P.	100.00%		(2,400,000)	20
21	V	43 State Replacement Taxes		MMN Partners, L.P.	100.00%	12,871	12,871	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 2,400,000			\$ 1,615,706	\$ * (784,294)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor-Naperville

0041285

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing Consultant	\$	Butterfield Health Care Management Group Inc.	100.00%	\$ 420	\$ 420	15
16	V	17 Management Fees	81,375	Butterfield Health Care Management Group Inc.	100.00%		(81,375)	16
17	V	19 Professional Services		Butterfield Health Care Management Group Inc.	100.00%	374	374	17
18	V	20 Licenses and Fees		Butterfield Health Care Management Group Inc.	100.00%	2,009	2,009	18
19	V	21 General Office Expense		Butterfield Health Care Management Group Inc.	100.00%	7,304	7,304	19
20	V	22 Employee Benefits and Payroll Taxes		Butterfield Health Care Management Group Inc.	100.00%	32,071	32,071	20
21	V	24 Travel and Seminar		Butterfield Health Care Management Group Inc.	100.00%	132	132	21
22	V	30 Depreciation		Butterfield Health Care Management Group Inc.	100.00%	195	195	22
23	V	34 Rent Facility and Grounds		Butterfield Health Care Management Group Inc.	100.00%	6,558	6,558	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 81,375			\$ 49,063	\$ * (32,312)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor-Naperville # 0041285 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Jafari	Stockholder	Executive Director	25.00%	49,970	18	45%	Salary	\$ 41,786	L17, C1	1
2	Nicholas Vangel	Stockholder	Executive Director	25.00%	29,874	18	45%	Salary	24,981	L17, C1	2
3	Christopher Vangel	Operating Supervisor	Administrative	0.00%	22,269	18	45%	Salary	18,622	L21, C1	3
4	Ladan Nili	Purchasing Director	Clerical	0.00%	3,702	18	45%	Salary	3,096	L21, C1	4
5											5
6											6
7											7
8											8
9	*- Compensation received from only one other nursing home										9
10	which was Butterfield Health Care, Inc. d/b/a Meadowbrook										10
11	Manor										11
12											12
13								TOTAL	\$ 88,485		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Meadowbrook Manor-Naperville

0041285

Report Period Beginning:

01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Butterfield Health Care Management Group
 Street Address 4 N. 645 School Road
 City / State / Zip Code St. Charles, IL 60175
 Phone Number (630) 443-8238
 Fax Number (630) 443-9379

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Consultant	Resident Days	167,872	2	\$ 923	\$	76,442	\$ 420	1
2	19	Professional Services	Resident Days	167,872	2	823		76,442	374	2
3	20	Licenses and Fees	Resident Days	167,872	2	4,412		76,442	2,009	3
4	21	General Office Expense	Resident Days	167,872	2	16,036		76,442	7,304	4
5	22	Employee Benefits and Payroll Taxes	Resident Days	167,872	2	70,424		76,442	32,071	5
6	24	Travel and Seminar	Resident Days	167,872	2	290		76,442	132	6
7	30	Depreciation	Resident Days	167,872	2	429		76,442	195	7
8	34	Rent - Facility and Grounds	Resident Days	167,872	2	14,400		76,442	6,558	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 107,737	\$		\$ 49,063	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	American National Bank		X	Mortgage	\$115,000.00	08/31/98	\$ 14,275,000	\$ 13,539,423	02/28/08	0.0750	\$ 1,040,614	1							
2	American National Bank		X	Amortization of Loan Costs							4,960	2							
3												3							
4												4							
5												5							
	Working Capital																		
6	American National Bank		X	Working Capital	N/A	05/06/98	667,534	667,534	02/28/08	0.0750	50,529	6							
7	Shareholder Loans	X		Working Capital	N/A	12/09/99	1,000,000	1,000,000	Demand	Prime	40,035	7							
8	Shareholder Loans	X		Working Capital	N/A	01/01/96	864,052	864,052	Demand	0.0000		8							
9	TOTAL Facility Related				\$115,000.00		\$ 16,806,586	\$ 16,071,009			\$ 1,136,138	9							
	B. Non-Facility Related*																		
10	Shareholder Loans	X		Working Capital	N/A	12/29/00	600,000	600,000	Demand			10							
11												11							
12							Investment Income Offset				(4,990)	12							
13							Interest Income Offset				(22,589)	13							
14	TOTAL Non-Facility Related						\$ 600,000	\$ 600,000			\$ (27,579)	14							
15	TOTALS (line 9+line14)						\$ 17,406,586	\$ 16,671,009			\$ 1,108,559	15							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Meadowbrook Manor-Naperville**# **0041285**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	202,000	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	\$	191,644	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(10,356)	3	
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	201,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5	
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	190,644	7	

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	17,482	8		
	1996	141,032	9		
	1997	194,559	10	13	FROM R. E. TAX STATEMENT FOR 1999 \$ 13
	1998	192,012	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	1999	191,644	12	15	LESS REFUND FROM LINE 6 \$ 15
1999 Taxes		191,644		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Estimated Increase		1.05			
Estimated Tax		201,226			
Use		201,000			

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:
89,000

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories
3

C. Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES
☐ NO

If so, please complete the following:

1. Total Amount Incurred:
242,409

2. Number of Years Over Which it is Being Amortized:
5

3. Current Period Amortization:
48,482

4. Dates Incurred:
1991-1995

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	148,410	1996	\$ 279,600	1
2					2
3	TOTALS	148,410		\$ 279,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	235		1996	1996	\$ 9,863,922	\$	40	\$ 246,598	\$ 246,598	\$ 1,214,848	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping Improvements			1996	22,797	1,140	15	1,520	380	6,080	9
10	Fence			1996	5,500	550	15	367	(183)	1,798	10
11	Land Improvements			1996	12,824		40	320	320	1,575	11
12	Doors			1997	5,961	596	20	298	(298)	1,043	12
13	Lanscaping Improvements (Shrubs, Trees, Evergreens)			1998	22,729	1,136	20	1,136		2,840	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 9,933,733	\$ 3,422		\$ 250,239	\$ 246,817	\$ 1,228,184	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 254,479	\$ 32,384	\$ 32,384	\$	5-10 yrs	\$ 131,470	37
38	Current Year Purchases	2,666	267	267		5 yrs	267	38
39	Fully Depreciated Assets	Allocation From Management Company						39
40	MMN Partners, L.P.	963,824		96,757	96,757	5-10 yrs	472,579	40
41	TOTALS	\$ 1,220,969	\$ 32,651	\$ 129,408	\$ 96,757		\$ 604,316	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 11,434,302	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 36,073	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 379,647	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 343,574	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,832,500	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from management company				6,558			6
7	TOTAL				\$ 6,558			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

N/A

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 6,930 Description: Offsite Storage \$2,105; Ice Machines \$3,930; Tent \$895

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>It is the policy of this facility to only hire certified nurses aides.</i> If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8						
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	L10a, C1	1477	hrs	\$	40,594		\$	1,477	\$	40,594	1			
2	Licensed Speech and Language Development Therapist	L10a, C3		hrs			917	28,199		917	28,199	2			
3	Licensed Recreational Therapist			hrs								3			
4	Licensed Physical Therapist	L10a, C1, C2	2684	hrs		75,042		3,306	2,684		78,348	4			
5	Physician Care			visits								5			
6	Dental Care			visits								6			
7	Work Related Program			hrs								7			
8	Habilitation			hrs								8			
9	Pharmacy	L39, C2		# of prescrpts				196,479			196,479	9			
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10			
11	Academic Education			hrs								11			
12	Exceptional Care Program											12			
13	Other (specify):											13			
14	TOTAL				\$	115,636	917	\$	28,199	\$	199,785	5,078	\$	343,620	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Meadowbrook Manor-Naperville

0041285

Report Period Beginning: 01/01/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 803,834	\$ 810,082	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 0)	2,413,251	2,413,251	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	234,040	234,040	6
7	Other Prepaid Expenses	37,865	40,387	7
8	Accounts Receivable (owners or related parties)	160,436	615,436	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,649,426	\$ 4,113,196	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		279,600	13
14	Buildings, at Historical Cost		9,876,746	14
15	Leasehold Improvements, at Historical Cost	56,987	56,987	15
16	Equipment, at Historical Cost	257,145	1,220,969	16
17	Accumulated Depreciation (book methods)	(139,474)	(1,832,500)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	49,308	242,409	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(48,488)	(238,428)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): See Sch 17A		13,225	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 175,478	\$ 9,619,008	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,824,904	\$ 13,732,204	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 213,190	\$ 213,190	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,464,052	2,464,052	29
30	Accrued Salaries Payable	178,183	178,183	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,115	16,115	31
32	Accrued Real Estate Taxes(Sch.IX-B)		201,000	32
33	Accrued Interest Payable	463	463	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	(287,432)	325,858	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,584,571	\$ 3,398,861	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	667,534	14,206,957	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - State			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 667,534	\$ 14,206,957	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,252,105	\$ 17,605,818	46
47	TOTAL EQUITY(page 18, line 24)	\$ 572,799	\$ (3,873,614)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,824,904	\$ 13,732,204	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

BUTTERFIELD HEALTH CARE II, INC.
D/B/A MEADOWBROOK MANOR - NAPERVILLE
PROVIDER # 0041285
12/31/2000

Schedule 17A

B. LONG-TERM ASSETS
LINE 22 OTHER LONG TERM ASSETS

	<u>OPERATING</u>	<u>AFTER CONSOLIDATION</u>
Loan Costs	0	24,798
Accumulated Amortization	0	(11,573)
	<u>0</u>	<u>13,225</u>

C. CURRENT LIABILITIES
LINE 36 OTHER CURRENT LIABILITIES

	<u>OPERATING</u>	<u>AFTER CONSOLIDATION</u>
Resident Credit Balances	322,178	322,178
Due to Related Parties	3,680	3,680
Accrued (Prepaid) Rent	(613,290)	
TOTAL	<u>(287,432)</u>	<u>325,858</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (87,032)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (87,032)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	858,203	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(198,372)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 659,831	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 572,799	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Meadowbrook Manor-Naperville

0041285

Report Period Beginning: 01/01/00

Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,514,085	1
2	Discounts and Allowances for all Levels	(930,207)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,583,878	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	534,104	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 534,104	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	37,907	13
14	Non-Patient Meals	2,329	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	219,930	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,504	19
20	Radiology and X-Ray	5,430	20
21	Other Medical Services	124,826	21
22	Laundry	5,584	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 411,510	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,389	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,389	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Bed Hold Revenue</u>	11,580	28
28a	<u>Wheelchair revenue</u>	5,023	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,603	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,556,484	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,510,154	31
32	Health Care	3,711,201	32
33	General Administration	1,424,239	33
	B. Capital Expense		
34	Ownership	2,543,429	34
	C. Ancillary Expense		
35	Special Cost Centers	380,242	35
36	Provider Participation Fee	129,016	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,698,281	40
41	Income before Income Taxes (line 30 minus line 40)**	858,203	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 858,203	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a Cash Basis Tax Payer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Meadowbrook Manor-Naperville

0041285

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,741	1,915	\$ 67,229	\$ 35.11	1
2	Assistant Director of Nursing	1,791	1,897	45,259	23.86	2
3	Registered Nurses	36,298	37,784	759,656	20.11	3
4	Licensed Practical Nurses	26,229	27,326	493,094	18.04	4
5	Nurse Aides & Orderlies	106,684	111,475	1,313,657	11.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,908	5,117	115,636	22.60	7
8	Rehab/Therapy Aides	7,592	8,418	86,181	10.24	8
9	Activity Director					9
10	Activity Assistants	11,940	12,508	107,607	8.60	10
11	Social Service Workers	177	189	1,958	10.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,033	42,045	350,104	8.33	15
16	Dishwashers					16
17	Maintenance Workers	6,164	6,580	77,413	11.76	17
18	Housekeepers	28,098	29,926	209,968	7.02	18
19	Laundry	10,211	10,838	73,921	6.82	19
20	Administrator	1,901	2,063	70,333	34.09	20
21	Assistant Administrator					21
22	Other Administrative	1,796	1,894	66,767	35.25	22
23	Office Manager					23
24	Clerical	16,938	18,187	300,285	16.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,217	3,718	34,008	9.15	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	21,742	23,090	350,848	15.19	33
34	TOTAL (lines 1 - 33)	327,460	344,970	\$ 4,523,924 *	\$ 13.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 10,118	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	Monthly	4,032	L10, C3	37
38	Nurse Consultant	288	18,123	L10, C3	38
39	Pharmacist Consultant	Monthly	6,000	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	917	28,199	L10a, C3	43
44	Activity Consultant	48	2,608	L11, C3	44
45	Social Service Consultant	56	2,660	L12, C3	45
46	Other(specify)				46
47	Quality Assurance	Monthly	3,265	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,309	\$ 99,005		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4	\$ 142	L10, C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	180	3,239	L10, C3	52
53	TOTAL (lines 50 - 52)	184	\$ 3,381		53

SEE ACCOUNTANTS' COMPILATION REPORT

BUTTERFIELD HEALTH CARE II, INC.
D/B/A MEADOWBROOK MANOR - NAPERVILLE
PROVIDER # 0041285
12/31/2000

Schedule 20A

XVIII. A. STAFFING AND SALARY COSTS
LINE 33 - OTHER

	# Of Hours Actually Worked	# Of Hours Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	Reference
Ward Clerks	1,737	1,819	19,051	10.47	10
Rehabilitation Nurse	642	645	15,113	23.43	10
Nursing Administration	12,352	13,176	232,376	17.64	10
Central Supply Clerk	1,831	1,868	19,260	10.31	10
Psycho-Social	5,180	5,582	65,048	11.65	12
	21,742	23,090	350,848		

See Accountants' Compilation Report

Facility Name & ID Number

Meadowbrook Manor-Naperville

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount	
Brenda Holder	Administrator	0.00%	\$ 50,907	Workers' Compensation Insurance		\$ 81,468	IDPH License Fee		\$ 200	
Jackie Lanter	Administrator	0.00%	18,311	Unemployment Compensation Insurance		42,231	Advertising: Employee Recruitment		27,480	
Robert Jafari	Executive Director	25.00%	41,786	FICA Taxes		345,135	Health Care Worker Background Check			
Nicholas Vangel	Executive Director	20.00%	24,981	Employee Health Insurance		117,334	(Indicate # of checks performed 112)		1,120	
Leslie Kolb	Administrator	0.00%	1,115	Employee Meals			Illinois Council on Long Term Care		7,844	
				Illinois Municipal Retirement Fund (IMRF)*		40,648	Miscellaneous Dues and Subscriptions		1,809	
							Miscellaneous Fees		1,928	
TOTAL (agree to Schedule V, line 17, col. 1)							Allocation From Management Company		620	
(List each licensed administrator separately.)			\$ 137,100							
B. Administrative - Other							Less: Public Relations Expense	()	
Description			Amount				Non-allowable advertising	()	
Butterfield Health Care Management Group Inc.			\$ 81,375				Yellow page advertising	()	
(Eliminated in column 7)										
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 81,375	TOTAL (agree to Schedule V, line 22, col.8)			\$ 626,816	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 41,001
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
C. Professional Services				Description			Description			Amount
Vendor/Payee		Type	Amount	Line #			Amount			
			\$				\$			
				N/A						
		See Schedule 21A	69,194							

* Attach copy of IMRF notifications

****See instructions.**

SEE ACCOUNTANTS' COMPILATION REPORT

BUTTERFIELD HEALTH CARE II, INC.
D/B/A MEADOWBROOK MANOR - NAPERVILLE
PROVIDER # 0041285
12/31/2000

Schedule 21A

XIX. C. PROFESSIONAL FEES

Vendor/Payee	Type	Amount
Health Data Systems Inc.	Computer Support	5,453
Health Outcomes Management Inc.	Computer Support	4,920
Mutual of Omaha - Medicare	Computer Support	443
Precision Repairs Inc.	Computer Support	460
Resource Systems	Bar Coding Support	1,044
Sunnyside Design Group Inc.	Fire Alarm Consultant	660
Personnel Planners	Unemployment Consultant	1,643
Transworld Systems Inc.	Collection Service	463
American Express Tax & Business	Accounting Services	12,858
Freedman Anselmo Lindberg	Collection Lawyer	4,199
Duane, Morris and Heckscher	Legal	26,772
Laner, Muchin, and Dombrow	Legal	7,341
Holleb & Coff	Legal	55
Blood Boose & Brizuela	Legal	56
Wildman, Harold, Allen & Dixon	Legal	2,827

Total Per Schedule V line 19, column 3 69,194

Professional Fees From Real Estate Partnership:

American Express Tax & Business	Accounting Services	14,481
Holleb & Coff	Legal	11,055
Wildman, Harold, Allen & Dixon	Legal	661
Harris Kessler & Goldstein LLC	Legal	13,205

Professional Fees Allocated From Management Company:

American Express Tax & Business	Accounting Services	342
Blood Boose & Brizuela	Legal	32

Total Before Adjustment For Non-allowables 108,970

Less: Non-allowable Professional Fees

A) Meadowbrook Manor of Naperville:		
Freedman Anselmo Lindberg	Collection Lawyer	(4,199)
Duane, Morris and Heckscher	Legal	(1,039)
Wildman, Harold, Allen & Dixon	Legal	(2,827)
Transworld Systems Inc.	Collection Services	(463)

B) MMN Partners (Real Estate Partnership):		
Holleb & Coff	Legal	(10,620)
Wildman, Harold, Allen & Dixon	Legal	(661)

Total Allowable Professional Services
Schedule V line 19 column 8 89,161

See Accountants' Compilation Report

BUTTERFIELD HEALTH CARE II, INC.
D/B/A MEADOWBROOK MANOR - NAPERVILLE
PROVIDER # 0041285
12/31/00

Schedule 21B

XVIII. G. SCHEDULE OF TRAVEL AND SEMINAR

Month	Description	Amount	Location	Employee	Seminar Title
Jan-00	Triton College	150	Chicago	Sharon Phillips	ICD 9 CM Coding
Mar-00	Oakton Community College	98	DesPlaines	Venus Rueda	PPS Seminar
Apr-00	Illinois Council on Long Term Care	75	Oak Lawn	Amanda Roll	The New MDS Version 2.10
Apr-00	Illinois Council on Long Term Care	75	Oak Lawn	Linda Coleman	The New MDS Version 2.11
Apr-00	Illinois Council on Long Term Care	75	Oak Lawn	Marya Jordan	The New MDS Version 2.12
Apr-00	Illinois Council on Long Term Care	125	Oak Lawn	Jackie Lamer	MDS 2.0 Update
Apr-00	Illinois Council on Long Term Care	125	Oak Lawn	Amanda Roll	MDS 2.0 Update
Apr-00	Illinois Council on Long Term Care	125	Oak Lawn	Venus Rueda	MDS 2.0 Update
Jun-00	Illinois Council on Long Term Care	280	Lincolnwood	Amanda Roll	MDS 2.0 Update
Jun-00	Illinois Council on Long Term Care	75	Oak Lawn	Jackie Lamer	MDS 2.0 Certification Course
Jul-00	Illinois Council on Long Term Care	60	Wheaton	Imelda Reyes	Survey Citations, Immediate Jeopardy, and t
Sep-00	Triton College	290	Rivergrove	Joy Dela Cruz	Foodservice Managers Sanitation Certificatic
Sep-00	Triton College	290	Rivergrove	Grace Hamid	Rehabilitation: Current Trends and Practices
Sep-00	Triton College	85	McHenry	Sharon Phillips	ICD 9 CM Coding Review
Oct-00	Healthcare Information Network	125	Naperville	Joy Dela Cruz	PPS Final (?) Rule
Oct-00	Healthcare Information Network	125	Naperville	Theresa Adolfo	PPS Final (?) Rule
Oct-00	Healthcare Information Network	125	Naperville	Trisha Muench	PPS Final (?) Rule
Oct-00	Healthcare Information Network	135	Naperville	Joe Suffi	PPS Final (?) Rule
Oct-00	Illinois CPA Foundation	165	Chicago	Joe Suffi	Health Care Compliance Fraud
Total - Allowable Travel and Semiar		<u>2,603</u>			

See Accountants' Compilation Report

the IDR Process
on Workshop
s

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

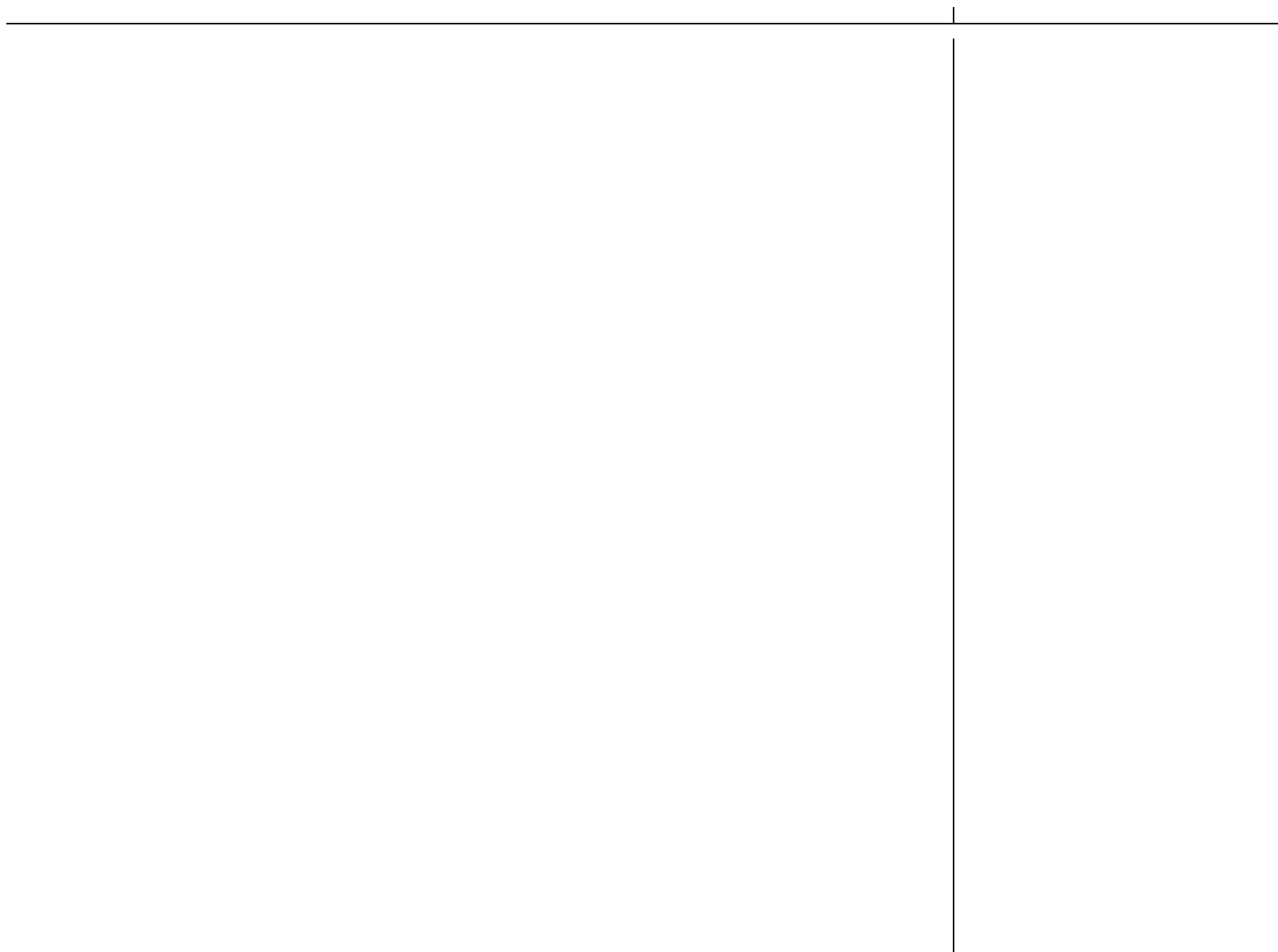
SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$7,844
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 89,885 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 129,016
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,329
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT



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